Regional Collaborative Summit 2017
Central Health Collaborative Updates & Success Stories

Connection & Partnership Development

The Central Health Collaborative (CHC) has become a neutral venue for collaboration and ultimately provides an open forum for various stakeholders to receive information, initiate connections, discuss challenges and problem-solve solutions.

An example of this partnership connection in action includes the development of a Medical Health Neighborhood (MHN) Survey for diabetes resources by PHD staff at Central District Health Department (CDHD). The survey was designed for SHIP cohort clinics to assess knowledge and understanding of local diabetes resources for prevention and self-management. This survey led to the implementation and facilitation of a MHN meeting for diabetes resources at CDHD. Clinic staff who attended the meeting shared resources and made connections for future referral to local resources. As a result we developed relationships with local community partners to increase availability and access to Diabetes Prevention Programs (DPP) workshops. Specifically, we are partnering with two SHIP clinics – St. Luke's McCall and Cascade Family Practice – and the Treasure Valley Family YMCA to establish a class in Valley County.

Alignment with Public Health District Programs

As part of our RC work, we continue to push alignment with public health district programs and resources, in order to have a broader impact in the development of the MHN and to ultimately reduce siloes among stakeholders. Examples include the following:

- **Prescription Drug Overdose Prevention**
  We have recruited two SHIP clinic providers (St. Luke's Cloverdale and FMRI) and a partnering clinical pharmacist (St. Luke's Health Partners) to build a team needed to proceed with the robust work of our Prescription Overdose Prevention Program (PDOP). Current discussions with these partners are centered around policy development and partnering with medical liaisons to assist clinics in answering questions related to opioid prescribing guidelines and the prescription drug monitoring program.

- **Obesity Prevention**
  The PHD facilitates a variety of activities to address obesity, including the implementation of the CHANGE tool, Let's Move child care workshops, representation on the Valley/Adams Health Coalition, attendance at Healthy Eating, Active Living (HEAL) meetings and organizing walkability audits in local community neighborhoods. As an RC, we look for opportunities to align our efforts with the objectives and goals of the Idaho Physical Activity and Nutrition program.

- **Tobacco Cessation**
  Our PHD policy analyst, SHIP Manager and QI Specialist work closely with one another to connect clinics to SMEs and corresponding supplemental resources for tobacco cessation. Specifically, Tobacco Quit line flyers have been implemented in SHIP clinics and brochures have been translated into Spanish at the request of our SHIP cohort 1 clinic staff at Primary Health Medical Group.

Development and Participation on Collaborative Workgroups

- **Regional QI Calls**
  Currently we work in partnership with Southwest District Health Department (Region 3) to connect regionally on the quality improvement work that is occurring our communities. We both facilitate a call with local Quality Improvement partners (Qualis, St. Luke's Health Partners, Saint Alphonsus Health Alliance, IPCA etc.) to discuss what each organization is working on and how we may partner together to reduce duplication of efforts.

- **Behavioral Health Integration**
  Currently, PHD staff (SHIP Manager) participate on the Behavioral Health Integration (BHI) workgroup with the state by attending subcommittee meetings. We are also involved in the facilitation of the Idaho Integrated Behavioral Health Network (IIBHN) and participate on the Region 4 Behavioral Health Board to align activities and understand areas where we might be able to improve collaboration or areas for program integration.

  We have also participated in the co-organization of specific BHI related events with Region 3, such as the most recent Let's Talk event for behavioral health and primary care providers. This event provided a forum for providers to come together to talk with one another about opportunities for integration, with the guidance of SMEs from the Farley Policy Center in Denver, Colorado.

- **Oral Health Integration**
  With a focus on oral health integration, we recently began participating on an oral health workgroup with Region 3. Currently we are having discussion with local dental providers to understand potential workflow processes for how a dentist may communicate with a PCMH/SHIP clinic when a patient arrives at a dental appointment with an elevated blood pressure. The hope is to develop a workflow and referral system between dentists and primary care provider clinics.

RC Subgrant – Caregiver Integration Project

Our RC, the CHC, determined a need to support family caregivers in their unique role as a member of the larger health care team. By taking advantage of the available RC subgrant opportunity, we are currently implementing a Caregiver Integration Project to educate and train clinic staff and CHEMS agencies on identifying and assessing caregivers, improving knowledge and referring to a local community care coordination agency for resource assistance and navigation. CHEMS agencies will also provide assessment and education in the field. We are in the process of beginning our educational trainings for clinic/CHEMS agency staff.